STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155695	B. WIN			02/16/	2012
NAME OF I	PROVIDER OR SUPPLIE	D	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIE	K		1400 W	FRANKLIN ST		
RIVERSI	DE VILLAGE			ELKHA	RT, IN 46516		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG K0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
K0000							
	A Life Safety C	ode Recertification	K00	000	The creation and submission	n of	'
	-	nsure Survey was			this plan of correction does no		
		the Indiana State			constitute an admission by this provider of any conclusion set		
	Department of				forth in the statement of		
	I	th 42 CFR 483.70(a).			deficiencies, or of any violation	n of	
	Leco. Gairee Wi				regulation. This provider		
	Survey Date: (02/16/12			respectfully requests that the 2567 plan of correction be		
		,,			considered the letter of credib	le	
	Facility Numbe	er: 003075			allegation and requests a post		
	Provider Numb				certification review on or after		
	AIM Number:				March 17, 2012.		
	7 militariber.	200301100					
	Surveyor: Amy	y Kelley, Life Safety					
	Code Specialis						
	Code Specialis	•					
	At this Life Saf	fety Code survey,					
		ge was found not in					
		th Requirements for					
	Participation ir	•					
	Medicare/Med						
	1	O(a), Life Safety					
	· ·	the 2000 edition of					
	the National Fi						
		FPA) 101, Life Safety					
		napter 19, Existing					
		· ·					
		ccupancies and 410					
	IAC 16.2.						
	This one story	facility with a					
	<u>-</u>	ent was determined					
	_ =	V (111) construction					
	to be of Type	v (111) CONSTRUCTION					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

PRINTED: 03/08/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155695	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPL 02/16/	ETED
	PROVIDER OR SUPPLIER DE VILLAGE	1400 W	.DDRESS, CITY, STATE, ZIP CO FRANKLIN ST RT, IN 46516	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 93 and had a census of 84 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/21/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:				

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Facility ID: 003075

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	T OF DEFICIENCIES OF CORRECTION	CORRECTION IDENTIFICATION NUMBER: A. BUILDING O2/16/2		ETED			
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN 46516		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ſĒ.	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0025 SS=D	Smoke barriers ar least a one half ho accordance with 8 terminate at an attribute at a second	e constructed to provide at our fire resistance rating in a.3. Smoke barriers may rium wall. Windows are ated glazing or by wired steel frames. A minimum ompartments are provided in of smoke barriers in fully entilating, and air in ms. 19.3.7.3, 19.3.7.5, avation and facility failed to eiling smoke aintained to provide resistance rating the construction (111). LSC 8.3.2 is barriers shall be in an outside wall to a resident care affect any staff in	K00		What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice? It is the practice of this provider to ensomoke barriers are constructed provide at least a one half hour fire resistance rating. No residents were identified to be affected by this finding. How wi you identify other residents having the potential to be affected by the same deficient practice and what corrective action will taken? All residents have the potential to be affected by this finding. The breaches in the basement ceiling have been appropriately patched to restor the one hour fire resistance rates as required. What measures with the deficient practice does not recur? The Maintenance Director will complete daily rounds throughout facility to maintain compliance. How will corrective action(s) be monitor	nts / ure d to r Il cted be re ting III mic	03/17/2012
		tion cut out of both			to ensure the deficient practice	e wil	

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Event ID: XTNQ21

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	OF CORRECTION IDENTIFICATION NUMBER: 155695	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPLETED 02/16/2012
	PROVIDER OR SUPPLIER DE VILLAGE	1400 W	ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST RT, IN 46516	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	layers of drywall in the basement corridor ceiling. Also, there was a twelve inch by twelve inch hole cut out of both layers of drywall in the ceiling of the sprinkler riser room. This was acknowledged by the Maintenance Director at the time of observation. 3.1–19(b)		not recur, i.e. what quality assurance program will be put into place? A Life Safety CQI will be utilized monthly x 3 mand then quarterly thereafter. Data will be submitted to the Committee for review and follow-up. The Maintenance Director, Executive Director and/or designee will be responsible for program compliance.	tool onths

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Event ID: XTNQ21

Facility ID: 003075

If continuation sheet

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	
		155695	B. WIN	G		02/16/	/2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KOVIDEK OK GOLTEIEN				FRANKLIN ST		
RIVERSI	DE VILLAGE			ELKHA	RT, IN 46516		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	1	DATE
K0027 SS=E		smoke barriers have at fire protection rating or are					
00 2		nick solid bonded wood					
	-	rotective plates that do not					
		from the bottom of the					
	•	d. Horizontal sliding doors14. Doors are self-closing					
		ng in accordance with					
	19.2.2.2.6. Swing	ing doors are not required					
		ss and positive latching is					
	1	0.3.7.5, 19.3.7.6, 19.3.7.7	1 1200	27	 What corrective action(s) will b	100	02/17/2012
	Based on obser		K00	27	accomplished for those reside		03/17/2012
	interview, the f				found to have been affected by		
	ensure 1 of 7 s				the deficient practice?It is the		
		ould restrict the			practice of this provider to ens		
	movement of s	moke for at least			door openings in smoke barrie have at least a 20-minute fire	rs	
		SC 19.3.7.6 requires			protection rating or are at least	t 1	
	doors in smoke	e barriers shall			3/4-inch thick solid bonded wo		
	comply with LS	C Section 8.3.4.			core. No residents were identif		
	LSC 8.3.4.1 red	quires doors in			to be affected by this finding. I will you identify other residents		
	smoke barrier s	shall close the			having the potential to be affect		
	opening leaving	g only the minimum			by the same deficient practice		
	clearance nece	ssary for proper			and what corrective action will	be	
	operation whic	h is defined as 1/8			taken?All residents have the potential to be affected by this		
	inch. This defi	cient practice could			finding. The door coordinator o	n	
	affect two of se	even smoke			the smoke barrier doors near		
	compartments.				resident room 210 has been		
					adjusted to allow the proper closing of the doors. What		
	Finding include	<u> </u>			measures will be put into place	e or	
					what systemic changes you wi		
	Based on obser	rvation with the			make to ensure that the deficie		
		ctor, Maintenance			practice does not recur?The Maintenance Director will		
	Supervisor,	,			complete daily rounds through	out	
		Laundry Supervisor			facility to maintain		
	_	or of Nursing on			compliance.How will the		
					corrective action(s) be monitor	ed	

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Event ID: XTNQ21

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155695	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 02/16/2012
RIVERSI	PROVIDER OR SUPPLIER DE VILLAGE	1400 W	ADDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN 46516	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
	02/16/12 at 1:15 p.m., the coordinating device on the smoke barrier doors near resident room 210 did not operate properly preventing the doors from closing completely leaving a six inch gap. This was confirmed by the Maintenance Supervisor at the time of observation. 3.1–19(b)		to ensure the deficient practic not recur, i.e. what quality assurance program will be pu into place? A Life Safety CQI twill be utilized monthly x 3 months and then quarterly thereafter. Data will be submitted to the Committee for review and follow-up. The Maintenance Director, Executive Director and/or designee will be responsible for program compliance.	t ool onths

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XTNQ21

Facility ID: 003075

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155695	B. WIN			02/16/	2012
	PROVIDER OR SUPPLIER DE VILLAGE			1400 W	ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST .RT, IN 46516		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0029 SS=E	One hour fire rated fire-rated doors) or fire extinguishing s 8.4.1 and/or 19.3.8 areas. When the a extinguishing syste areas are separate smoke resisting pareself-closing an protective plates the inches from the border permitted. 19.3. Based on observing the combustibles of the sure the corroller utility stocombustibles of the sure feet in swith a self closideficient praction resident near the station. Findings include Based on observing the processing include the corroller of the corroller o	d construction (with ¾ hour ran approved automatic system in accordance with 5.4 protects hazardous approved automatic fire em option is used, the ed from other spaces by artitions and doors. Doors id non-rated or field-applied hat do not exceed 48 obtom of the door are 2.1 evation and facility failed to ridor door to 1 of 3 orage rooms with measuring over 50 size was provided ing device. This ce could affect any he Heritage nurses' le: Evation with the etor, Maintenance Laundry Supervisor or of Nursing on 2:45 p.m., the othe Heritage hall om measuring over	K00		What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice? It is the practice of this provider to ensone hour fire rated construction (with 3/4 hour fire-rated doors) an approved automatic fire extinguishing system protects hazardous areas. No resident were identified to be affected by this finding. How will you idention other residents having the potential to be affected by the same deficient practice and who corrective action will be taken residents have the potential to affected by this finding. A self closing device was installed in corridor door to the Heritage holds clean utility room. What measures will be put into place what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Director will complete daily rounds through facility to maintain compliance. How will the	nts y ure n or s y the all e or III	03/17/2012
ı	briefs lacked a	self closing device.			corrective action(s) be monitor	eu	

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	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155695	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 02/16/2012
	PROVIDER OR SUPPLIER DE VILLAGE	1400 W ELKHA	ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST RT, IN 46516	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	This was confirmed by the Maintenance Supervisor at the time of observation. 3.1–19(b)		to ensure the deficient practic will not recur, i.e. what quality assurance program will be pure into place? A Life Safety CQI the will be utilized monthly x 3 months and then quarterly thereafter. Data will be submitted to the Committee for review and follow-up. The Maintenance Director, Executive Director and/or designee will be responsible for program compliance.	t cool onths

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Event ID: XTNQ21

Facility ID: 003075

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	A. BUILDING 01		COMPL	ETED
		155695	B. WIN			02/16/	2012
			Б. WПV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			/ FRANKLIN ST		
RIVERSI	DE VILLAGE				RT, IN 46516		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)		DATE
K0038		anged so that exits are					
SS=E	with section 7.1.	at all times in accordance					
l l	Based on obser		K00	138	What corrective action(s) will b	e i	03/17/2012
			1100	.50	accomplished for those reside		03/1//2012
	interview, the f				found to have been affected by	y	
	ensure 1 of 1 a				the deficient practice?It is the		
	room exit acce				practice of this provider to ens exit access is arranged so that		
	readily accessil				exits are readily accessible at		
		it all times. This			times. No residents were		
	deficient practi	ce could affect any			identified to be affected by this		
	of the resident	s evacuated			finding.How will you identify ot		
	through the as	sisted dining room			residents having the potential		
	exit door.				be affected by the same defici- practice and what corrective	ent	
					action will be taken?All resider	nts	
	Findings includ	le:			have the potential to be affected	ed	
					by this finding.To ease the		
	Rased on an oh	servation with the			signage confusion, the		
		ctor, Maintenance			"Emergency Exit Only" sign wa removed from the assisted din		
		Lioi, Maintenance			room exterior door. We intend	-	
	Supervisor,	(Lavarday Comanday			maintain this door as "Not an		
	_	Laundry Supervisor			Exit." What measures will be p	out	
		or of Nursing on			into place or what systemic		
		:08 p.m., the exit			changes you will make to ensuthat the deficient practice does		
	door from the				not recur?The Maintenance	,	
		led "Emergency Exit			Director will complete daily		
	Only" and "Not	an Exit."			rounds throughout facility to		
	Additionally, th	ne door had a			maintain compliance.How will		
	deadbolt and a	sliding latch bolt			corrective action(s) be monitor to ensure the deficient practice		
	near the top of	the door. Based			will not recur, i.e. what quality	•	
	on an interview	with the			assurance program will be put		
	Maintenance Su	upervisor and the			into place?A Life Safety CQI to		
		ctor at the time of			will be utilized monthly x 3 mor	nths	
		either could confirm			and then quarterly thereafter. Data will be submitted to the C	·OI	
	•	or was used as an			Committee for review and	, ((1)	
					follow-up. The Maintenance		
	emergency exit	L			<u> </u>		

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	of correction identification number: 155695	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 02/16/2012
	PROVIDER OR SUPPLIER	1400 W	ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST	
	DE VILLAGE		.RT, IN 46516	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
TAG	3.1–19(b)	TAG	Director, Executive Director and/or designee will be responsible for program compliance.	DATE

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	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SU PLAN OF CORRECTION IDENTIFICATION NUMBER: 01 COMPLET		ETED				
		155695	B. WIN			02/16/	/2012
	PROVIDER OR SUPPLIE DE VILLAGE	R		1400 W	ADDRESS, CITY, STATE, ZIP CODE I' FRANKLIN ST RT, IN 46516		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0044 SS=E	Horizontal exits, i with 7.2.4. 19.2 Based on obse interview, the ensure 2 of 2 arranged to au and latch. LSC horizontal exit accordance wi 7.2.4.3.8 requiself closing or in accordance addition NFPA Fire Doors and 2–1.4.1 requir mechanisms is overcome fire latch mechanisms sovercome fire latch ing is ach operation. The could affect ar 500 hall and a kitchen. Findings include Based on obse executive Directions, Housekeeping and the Directions.	fused, are in accordance 2.2.5 crvation and facility failed to fire door sets were atomatically close 2.19.2.2.5 requires to be in th 7.2.4 and ires fire doors to be automatic closing with 7.2.1.8. In 80, Standard for I Windows at less all closing hall be adjusted to resistance of the sem so positive ieved on each door is deficient practice by residents on the ny resident near the	K00		What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice? It is the practice of this provider to ensifire door sets are arranged to automatically close and latch. residents were identified to be affected by this finding. How wiyou identify other residents having the potential to be affected by the same deficient practice and what corrective action will taken? All residents have the potential to be affected by this finding. Positive latching hardw was installed on the fire door so by the Beauty Salon (500 Hall and the kitchen fire door. What measures will be put into place what systemic changes you with make to ensure that the deficient practice does not recur? The Maintenance Director or designeewill complete daily rounds throughout facility to maintain compliance. How will corrective action(s) be monitor to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety CQI to will be utilized monthly x 3 morand then quarterly thereafter. Data will be submitted to the Committee for review and follow-up. The Maintenance Director, Executive Director	nts y ure No ill cted be vare set), t e or ill ent the red e	03/17/2012
	operation. The could affect are 500 hall and a kitchen. Findings includes Based on obset Executive Direct Supervisor, Housekeeping and the Direct 02/16/12 from	is deficient practice ny residents on the ny resident near the de: rvation with the ctor, Maintenance /Laundry Supervisor or of Nursing on			practice does not recur?The Maintenance Director or designeewill complete daily rounds throughout facility to maintain compliance.How will corrective action(s) be monitor to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A Life Safety CQI to will be utilized monthly x 3 monand then quarterly thereafter. Data will be submitted to the CC committee for review and follow-up.The Maintenance	the red e c c cool nths	

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Event ID: XTNQ21

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PRINTED: 03/08/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155695	A. BUILDING B. WING	COMPLETED 02/16/2012	
	ROVIDER OR SUPPLIER DE VILLAGE	STREET ADDRESS, CITY 1400 W FRANKLIN ELKHART, IN 46516	ST	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORR)	ERS PLAN OF CORRECTION ECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE	ΓΙΟΝ
	facility, a block wall extended above the roof at the 500 hall and the kitchen cross corridor doors. Based on observation with the Maintenance Supervisor at 2:35 p.m. on 02/16/12, the 500 hall and the kitchen fire doors lack latching hardware and did not latch into the frame. This was confirmed by the Maintenance Supervisor at the time of observation. 3.1–19(b)	compliance		

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		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155695	B. WING		02/16/2012
	PROVIDER OR SUPPLIEF	2	1400 V	ADDRESS, CITY, STATE, ZIP CODE V FRANKLIN ST ART, IN 46516	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES SCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0050 SS=F	varying conditions shift. The staff is and is aware that routine. Respons conducting drills is competent person exercise leadersh conducted between announcement madible alarms. Based on recording tried drill quarterly on earliest 4 completed deficient practice occupants. Findings includes Based on review Fire Drill Report Maintenance Streep Drill	rd review and facility failed to Is were conducted ach shift for 1 of the ed quarters. This ice could affect all de: w of the "Monthly rt" with the upervisor and the /Laundry Supervisor at 10:55 a.m., there of a second and drill for the fourth 1. Based on an the Maintenance he time of record ility was without a	K0050	What corrective action(s) will be accomplished for those reside found to have been affected be the deficient practice? It is the practice of this provider to ensifire drills are held at unexpected times under varying conditions least quarterly on each shift. It residents were identified to be affected by this finding. How we you identify other residents having the potential to be affected by the same deficient practice and what corrective action will taken? All residents have the potential to be affected by this finding. A new Maintenance Director was hired in the Mont December, 2011, and fire drills have remained current. What measures will be put into place what systemic changes you we make to ensure that the deficient practice does not recur? The Maintenance Director will complete fire drills as required Fire drill reports will be reviewed at each monthly Safety Committee Meeting. How will to ensure the deficient practice.	ure ed s at No ill cted be h of s e or ill ent .

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XTNQ21

Facility ID: 003075

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PRINTED: 03/08/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695 A. BUILDING B. WING	COMPLETED 02/16/2012
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	(X5) COMPLETION DATE
3.1–19(b) 3.1–51(c) will not recur, i.e. what quality assurance program will be put into place?Fire drill reports will reviewed monthly at the Safety Committee Meeting, and at the monthly COI Committee for review and follow-up.The Maintenance Director, Executiv Director and/or designee will be responsible for program compliance.	be /

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01 COMPLET			ETED		
		155695		3. WING 02/16/		2012	
NAME OF B	NOVADED OD GUDDI IED				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1400 W	FRANKLIN ST		
RIVERSI	DE VILLAGE			ELKHAI	RT, IN 46516		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG K0056		matic sprinkler system, it is		TAG	DEFICIENCE		DATE
SS=E	installed in accord Standard for the Ir Systems, to provid all portions of the properly maintaine NFPA 25, Standar Testing, and Main Fire Protection Sy supervised. There water supply for the sprinkler systems	ance with NFPA 13, Installation of Sprinkler Ide complete coverage for Ide building. The system is Ide in accordance with Ide for the Inspection, Itenance of Water-Based					
		cted to the building fire					
	Based on obserinterview, the fensure 2 of 5 sthe 500 hall and heads in the Heseparated by Afrequired by NF Section 5–6.3.4 sprinklers be lot than six feet many resident in the Heritage Lot of a fire emerging Findings include Based on obsering Executive Direct Supervisor,	rvation and facility failed to prinkler heads in d 2 of 6 sprinkler eritage Lounge were t least six feet as PA 13. NFPA 13 frequires ocated no closer leasured on center. Oractice could affect the 500 hall and ounge in the event ency.	K00	56	What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice? It is the practice of this provider to ensign sprinkler heads are separated at least six feet. No residents were identified to be affected by this finding. How will you identified to the residents having the potential to be affected by the same deficient practice and who corrective action will be taken? residents have the potential to affected by this finding. PIPE In removed one of the two sprink heads that were cited on the 5 hall that were within 12 inches each other and one of the two sprinkler heads that were cited the Heritage Lounge that were within three feet of each other. What measures will be printo place or what systemic changes you will make to ensuthat the deficient practice does not recur? The Maintenance	nts / ure by fy nat PAII be nc. ler 00 of I in ut	03/17/2012

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	of Correction identification number: 155695	(X2) MULTIPLE CON A. BUILDING B. WING	01	COMPLETED 02/16/2012
	PROVIDER OR SUPPLIER DE VILLAGE	1400 W F	DDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN 46516	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
	and the Director of Nursing on 02/16/12 between 12:40 p.m. and 1:13 p.m., the 500 hall had two sprinkler heads located twelve inches apart and the Heritage Lounge had two sprinkler heads located three feet apart. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1–19(b)		Director or designee will comp daily rounds throughout facility maintain compliance. How will corrective action(s) be monito to ensure the deficient practic will not recur, i.e. what quality assurance program will be pure into place? A Life Safety CQI to will be utilized monthly x 3 monand then quarterly thereafter. Data will be submitted to the Committee for review and follow-up. The Maintenance Director, Executive Director and/or designee will be responsible for program compliance.	y to the red e t ool onths

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01			COMPLETED	
		155695	B. WING			02/16/	2012
NAME OF P	DOUDED OF GUIDNI 155		' 	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1400 W	FRANKLIN ST		
RIVERSI	DE VILLAGE			ELKHAI	RT, IN 46516		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL	F	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG K0064		LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCI)	I	DATE
SS=E		guishers are provided in all ancies in accordance with					
	9.7.4.1. 19.3.5.6						
	Based on obser		K006	54	What corrective action(s) will be		03/17/2012
	interview, the f	acility failed to			accomplished for those reside		
		fire extinguishers			found to have been affected by the deficient practice? It is the	y	
		d 1 of 3 basement			practice of this provider to ens	ure	
		ers requiring a 12			portable fire extinguishers are		
	_	c test were emptied			provided in all health care		
		to the applicable			occupancies. No residents we identified to be affected by this		
	_	rocedures every six			finding. Fire extinguishers have		
		ed by NFPA 10,			been tested per requirement.		
	Standard for Po	-			will you identify other residents		
					having the potential to be affective	cted	
	Extinguishers,	·			by the same deficient practice and what corrective action will	be	
	·	oractice could affect			taken?All residents have the		
	-	esidents on the 100			potential to be affected by this		
	-	ımber of staff in the			finding.Fire Safety Co. perform		
	basement.				the required 6 year test on the 100 hall and basement fire		
					extinguishers that were		
	Findings includ	le:			cited.What measures will be p	ut	
					into place or what systemic		
		rvation with the			changes you will make to ensuthat the deficient practice does		
	Executive Direc	ctor, Maintenance			not recur?The Maintenance	•	
	Supervisor,				Director will keep a calendar o	f	
	Housekeeping/	Laundry Supervisor			projected dates for ordering fir	е	
	and the Directo	or of Nursing on			extinguisher testing and		
	02/16/12 from	າ 1:05 p.m. to 2:34			maintenance. Maintenance Director to annually review las	t	
	p.m., the main	tenance tag on the			date of testing and maintenand		
	100 hall and th	ne basement fire			on each extinguisher.How will	the	
	extinguishers i	ndicated the last			corrective action(s) be monitor		
	six year test wa	as completed June			to ensure the deficient practice will not recur, i.e. what quality	=	
	2005 and July 2	2005. This was			assurance program will be put		
	-	by the Maintenance			into place?A Life Safety CQI to	ool	
	Supervisor at th	-			will be utilized monthly x 3 m	nths	

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STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 1400 W FRANKLIN ST ELKHART, IN 46516	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) OMPLETION DATE
observation. 3.1–19(b) and then quarterly thereafter. Data will be submitted to the COI Committee for review and follow-up.The Maintenance Director, Executive Director and/or designed will be responsible for program compliance.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	01	COMPLETED	
		155695	B. WING		02/16/2012	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			W FRANKLIN ST		
RIVERSI	DE VILLAGE			ART, IN 46516		
				1		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
K0066		ns are adopted and include				
SS=E	no less than the lo	ollowing provisions:				
	or compartment w combustible gases stored and in any and such area is p NO SMOKING or symbol for no smo (2) Smoking by pa responsible is prol direct supervision. (3) Ashtrays of no safe design are pr smoking is permitt (4) Metal containe	ntients classified as not hibited, except when under ncombustible material and ovided in all areas where				
	are readily availab	ole to all areas where				
·	Based on obser		K0066	What corrective action(s) will b	pe 03/17/2012	
	interview, the f			accomplished for those resider	l l	
	ensure 1 of 1 a	•		found to have been affected by the deficient practice? It is the	′	
	smoking was p	ermitted for staff		practice of this provider to ens	ure	
		vas maintained and		smoking areas are maintained		
		ainer with a self		and provided with a metal		
	closing cover w			container with a self-closing cover. No residents were		
	_	leficient practice		identified to be affected by this	;	
	could affect an			finding.How will you identify ot	her	
		ugh the employee's		residents having the potential	l l	
	entrance.	agn the employees		be affected by the same deficient	ent	
	CHUANCE.			practice and what corrective action will be taken?All resider	nts	
	Findings includ			have the potential to be affected by this finding. The area where smoking is permitted for reside	ed ents	
	Based on an ob	servation with the		and staff has been cleaned up		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING 01		COMPLETED	
		155695	B. WING		02/16/2012	
AND PLAN	PROVIDER OR SUPPLIED SUMMARY: (EACH DEFICIENT REGULATORY OF Maintenance Staff of area was proviousis" which is with a long nebutts. At least cigarette butts the ground neentrance door area. A metal provided at the it was not equiclosing cover.	IDENTIFICATION NUMBER: 155695 R STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) Supervisor on 1:40 a.m., the designated smoking ided with a "smokers is a metal container ick used for cigarette t one hundred is were observed on ar the employee's in the smoking ashtray was also e entrance door but ipped with self This was by the Maintenance	A. BUILDING B. WING STREET 1400 W	ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST .RT, IN 46516 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) and a metal ashtray with a self-closing cover was purchas and placed in the area. What measures will be put into place what systemic changes you w make to ensure that the defici practice does not recur? The Maintenance Director and or designee to complete daily rounds to ensure smoking are remains maintained and prope ashtray is in place. How will the corrective action(s) be monitor to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety CQI to will be utilized monthly x 3 mo and then quarterly thereafter. Data will be submitted to the C Committee for review and follow-up. The Maintenance	COMPLETED 02/16/2012 (X5) COMPLETION DATE sed e or ill ent a er e red e cool nths	
	observation. 3.1–19(b)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
I LE I LIN	o. condenon	155695	A. BUILDING	<u> </u>	02/16/2012
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	· · · · · ·
NAME OF F	PROVIDER OR SUPPLIER			V FRANKLIN ST	
RIVERSI	DE VILLAGE			ART, IN 46516	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	NATE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K0069 SS=E	Cooking facilities a accordance with 9	are protected in 1.2.3. 19.3.2.6, NFPA 96			
00	Based on obser		K0069	What corrective action(s) will	be 03/17/2012
	interview, the f		110003	accomplished for those resid	
		nanual hood fire		found to have been affected	•
				the deficient practice?It is the	
		activation devices		practice of this provider to er cooking areas are protected	
		the path of egress.		manual hood fire extinguishing	
		equires commercial		activation device being locate	_
	cooking equipr	nent to be in		a path of egress or exit. No	
	compliance wit	h NFPA 96, 1998		residents were identified to b	I
	Edition, Standa	rd for Ventilation		affected by this finding. How	Will
	Control and Fir	e Protection of		you identify other residents having the potential to be aff	erted
	Commercial Co	Commercial Cooking Operations.		by the same deficient practic	
		tion 7–5.1 states, a		and what corrective action w	
	readily accessil			taken?All residents have the	
	•	ion shall be located		potential to be affected by th	
		thes and 60 inches		finding.Fire Safety Co. relocation the manual hood fire extingu	
				activation device to a path of	
		, located in a path		egress or exit out of dietary.\	
	of exit or egres	<u> </u>		measures will be put into pla	
	•	lentify the hazard protected.		what systemic changes you	
	·	oractice could affect		make to ensure that the define practice does not recur? The	cient
	any kitchen sta	ff and residents in		Maintenance Director and or	
	the dining roor	n.		designee to complete month	
				rounds to ensure proper loca	ation
	Findings includ	le:		and maintenance of activation	
				device. How will the corrective	
	Based on an ob	servation with the		action(s) be monitored to ensitive deficient practice will not	
		ctor, Maintenance		recur, i.e. what quality assura	
	Supervisor,	, , , , , , , , , , , , , , , , , , , ,		program will be put into place	e?A
	•	Laundry Supervisor		Life Safety CQI tool will be u	
		or of Nursing on		monthly x 3 months and ther	
				quarterly thereafter. Data wi submitted to the CQI Commi	
	02/16/12 at 2:	· · · · · ·		for review and follow-up.The	
	activation devic	ce for the kitchen		Maintenance Director, Execu	
			1	i	

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	of Correction identification number: 155695	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPI 02/16	LETED
	PROVIDER OR SUPPLIER DE VILLAGE	1400 W	ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST .RT, IN 46516		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE OPRIATE	(X5) COMPLETION DATE
	hood fire protection system was mounted on the wall above the preparation sink which was not in the path of exit or egress. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1–19(b)		Director and/or designee or responsible for program compliance.	vill be	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					· ′	TE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695		A. BUILDING 01				COMPLETED 02/16/2012	
		155695	B. WIN			02/16/	2012	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST			
RIVERSI	DE VILLAGE				RT, IN 46516			
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE	
K0070 SS=E	Portable space he prohibited in all he except in non-slee areas where the h devices do not exception areas C 19.7	ating devices are salth care occupancies, sping staff and employee eating elements of such ceed 212 degrees F. (100 7.8	K00	070	What corrective action(s) will b		03/17/2012	
	review, the facilenforce the polof 1 portable sofacility in according 101, Section 19 deficient praction resident in the room. Findings include Based on an observative Director Supervisor, Housekeeping/and the Director 02/16/12 at 11 fireplace with a in the Cottage on record review heater policy we Supervisor at 1	Sased on an observation with the executive Director, Maintenance supervisor, Housekeeping/Laundry Supervisor and the Director of Nursing on 02/16/12 at 1:25 p.m., an electric ireplace with a heater was located in the Cottage dining room. Based on record review of the space heater policy with the Maintenance supervisor at 11:25 a.m., the facility does not allow space			accomplished for those reside found to have been affected by the deficient practice? It is the practice of this provider to ensithat no portable space heating devices are located in health coccupancy areas. All resident on the Cottage were identified be affected by this finding. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will taken? All residents have the potential to be affected by this finding. The heating mechanism for the fireplace in the Cottage was disabled by facility maintenance. What measures were be put into place or what system changes you will make to ensurthat the deficient practice does not recur? The Maintenance Director and or designee to complete daily rounds to ensurthe the deficient practice will not recur, i.e. what quality assurant program will be put into place? Life Safety CQI tool will be utilimonthly x 3 months and then quarterly thereafter. Data will submitted to the CQI Committee.	nts y ure lare s to y cted be m will emic ure s re ye lare be lare be lare be	03/17/2012	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155695	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMP1 02/16	
NAME OF P	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	3	
RIVERSI	DE VILLAGE			/ FRANKLIN ST .RT, IN 46516		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	TION D BE OPRIATE	(X5) COMPLETION DATE
				for review and follow-up.T Maintenance Director, Exe Director and/or designee vresponsible for program compliance.	he ecutive	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	Ì	LDING	ONSTRUCTION 01	(X3) DATE COMPL 02/16 /	ETED
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K0144 SS=C	exercised under lomonth in accordar 3.4.4.1. Based on interverview, the facing the off site fuel emergency generalized and Standby Potagon Chapter 3, Emesupply (EPS), 3-states the follow sources shall be for the emergency general beautiful to the emergency or vapor with draw or	riew and record lity failed to ensure source for 1 of 1 erators was from a NFPA 110 1999 rd for Emergency wer Systems, ergency Power -1.1 Energy Sources wing energy e permitted for use ncy power supply eum products at essure troleum gas (liquid rawal) rithetic gas Level 1 locations where the nterruption of pplies is high (e.g., ake, flood damage ed utility n-site storage of ergy source ow full output of power supply o be delivered for	K01	44	What corrective action(s) will accomplished for those reside found to have been affected be the deficient practice? It is the practice of this provider to ensith the off site fuel source for emergency generator is from reliable source. No residents were identified to be affected by this finding. How we you identify other residents having the potential to be affected by the same deficient practice and what corrective action will taken? All residents have the potential to be affected by this finding. A letter of reliability fro NIPSCO meeting all of the requirements as outlined in NI 110 and ensuring the offsite for the emergency generator of the form a reliable source has been obtained and will be kept on five the measures will be put into place or what systemic chang you will make to ensure that the deficient practice does not recomply the deficient practice does not recomply in the corrective action of the placement of letter monthly. How will the corrective action of the put into place. Will review placement of letter monthly. How will the corrective action of the put into place. Life Safety CQI tool will be utimonthly x 3 months and then	ents by sure a erill cted b I be s m FPA uel was en ide o cur? d or f and e ure nce ?A	03/17/2012

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155695	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 02/16/2012
	PROVIDER OR SUPPLIER DE VILLAGE	1400 W	ADDRESS, CITY, STATE, ZIP CODE I FRANKLIN ST RT, IN 46516	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	required, with the provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. This deficient practice could affect all residents, staff and visitors. Findings include:		quarterly thereafter. Data will submitted to the CQI Committ for review and follow-up.The Maintenance Director, Execut Director and/or designee will be responsible for program compliance.	be ee ive
	Based on interview with the Executive Director and the Maintenance Supervisor on			

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155695	(X2) MULTIPLE CC A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 02/16/2012		
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION		
	11/15/10 at 11:05 a.m., the fuel source for the emergency generator was natural gas. Additionally, based on record review, the facility did have a letter from their natural gas provider (NIPSCO) which was undated, but the letter did not include all the items above required for a letter confirming the reliability of a natural gas fuel source for an emergency generator. The letter lacked supporting statements of reliability of natural gas, the low probability of interruption of the natural gas service and a signature of a technical person. This was acknowledged by the Executive Director and the Maintenance Supervisor during the time of record review. 3.1–19(b)					

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	OF CORRECTION	IDENTIFICATION NUMBER: 155695	(X2) MULTIPLE CC A. BUILDING B. WING	01	02/16	LETED 5/2012
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE			1400 W	ADDRESS, CITY, STATE, ZIF / FRANKLIN ST .RT, IN 46516	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building 01		COMPLETED			
		155695		B. WING		02/16/2012	
NAME OF B	DOLUDED OD GLIDDLIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1400 W	FRANKLIN ST		
RIVERSIDE VILLAGE			ELKHA	RT, IN 46516			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG K0147		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
SS=E	Electrical wiring an accordance with N	IFPA 70, National					
	Electrical Code. 9.						
	1. Based on ob	oservation and	K01	47	What corrective action(s) will b		03/17/2012
	interview, the f	acility failed to			accomplished for those reside		
		lexible cords such			found to have been affected by the deficient practice? It is the	y	
		n cord were not			practice of this provider to ens	ure	
	used as a subs				that all electrical wiring and		
	wiring. LSC 9.1				equipment is in accordance wi	th	
	-	g and equipment to			NFPA 70. No residents were identified to be affected by this		
	'-	FPA 70, National			finding. How will you identify ot		
	Electrical Code				residents having the potential	to	
		e 400-8 requires,			be affected by the same defici-	ent	
	unless specifica	·			practice and what corrective action will be taken?All resider	nte	
	· •	and cables shall not			have the potential to be affected		
		ubstitute for fixed			by this finding.All light duty		
					extension cords were removed	t	
	wiring of a stru				from the facility. A GFCI was installed in the medication roof	m	
	=	ce could affect any near the Assistant			on the Liberty hall. What	11	
					measures will be put into place	e or	
	Director of Nur	-			what systemic changes you wi		
		103 and the MDS			make to ensure that the deficie	ent	
	Coordinator's o	office.			practice does not recur?Daily rounds will be made by the		
					Environmental Services		
	Findings includ	le:			Supervisor and/or designee to		
					ensure no light duty extension cords have been placed.Staff		
		servation with the			in-serviced on observing new l	iaht	
		tor, Maintenance			duty extension cord(s) being p	•	
		ekeeping/Laundry			into use, removing the cord(s)),	
	=	the Director of			and reporting to the Environmental Services		
	_	/16/12 between			Supervisor of finding. How will	the	
	12:45 p.m. and	·			corrective action(s) be monitor		
		s were noted in the			to ensure the deficient practice		
	following locat	ions:			will not recur, i.e. what quality		
	a) a regular lig	ht weight			assurance program will be put		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	(X2) MULT A. BUILDI B. WING		01	(X3) DATE (COMPL 02/16/	ETED
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
	and providing prefrigerator in to Director of Nur b) a regular lig extension cord power to a lam weight extension providing power in resident room c) a heavy weight was plugged in power to a mic refrigerator in the Coordinator's of This was acknown Maintenance Dof observations. 2. Based on obsinterview, the fensure 1 of 1 Lengure 1 o	the Assistant sing's office tht weight was providing p and another light on cord was er to another lamp m 103. ght extension cord and providing rowave and a the MDS office. whedged by the firector at the time s. eservation and acility failed to liberty hall wet medication rooms with ground fault			into place? A Life Safety CQI to will be utilized monthly x 3 morand then quarterly thereafter. Data will be submitted to the C Committee for review and follow-up. The Environmental Services Supervisor, Executive Director and/or designee will b responsible for program compliance.	nths :QI	

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NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) NFPA 70, 517–20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER: A. BUILDING	X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) NFPA 70, 517–20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI		155695	155695	02/16/2012
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) NFPA 70, 517–20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI			1400 W FRANKLIN ST	
requires all receptacles and fixed equipment within the area of the wet location to have GFCI	PREFIX (EACH D	EACH DEFICIENCY MUST BE PERCEDED BY FULL	ENCY MUST BE PERCEDED BY FULL PREFIX PREFIX PREFIX PREFIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any staff using the Liberty hall medication room sink in the event of an electrical short. Findings include: Based on an observation with the Executive Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor on 02/16/12 at 1:40 p.m., the Liberty hall medication room had an electrical receptacle on the wall within three feet of the sink which was not provided with GFCI protection to prevent electric shock. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1–19(b)	requires a equipment wet locate protection the contact and electrical subject to practice of using the room sindefectrical Findings Based on Executive Supervisor Housekeed on 02/16 Liberty has an electrical within the was not protection shock. To the Maint time of or the second contact in the second contac	aires all receptacles and fixed ipment within the area of the location to have GFCI rection. Moisture can reduce contact resistance of the body, electrical insulation is more ject to failure. This deficient retice could affect any staffing the Liberty hall medication mink in the event of an arrical short. Itings include: Led on an observation with the rective Director, Maintenance ervisor, sekeeping/Laundry Supervisor 12/16/12 at 1:40 p.m., the rety hall medication room had electrical receptacle on the wall ain three feet of the sink which not provided with GFCI rection to prevent electric rection to prevent	eceptacles and fixed ithin the area of the ito have GFCI Moisture can reduce esistance of the body, insulation is more lure. This deficient d affect any staff erty hall medication the event of an rt. ude: bbservation with the ector, Maintenance g/Laundry Supervisor at 1:40 p.m., the nedication room had eceptacle on the wall feet of the sink which ided with GFCI prevent electric was acknowledged by nce Supervisor at the	

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